Series on Democracy and Health

PVOs and NGOs: Promotion of Democracy and Health

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Summary

In recent years, private voluntary organizations (PVOs) and nongovernmental organizations (NGOs) have emerged as major collective actors in international development activities. This paper identifies challenges inherent in working with PVOs and NGOs to promote health at the community level while, concurrently, promoting democracy.

PVOs and NGOs in the North and the South have demonstrated their capacity to mobilize people into organized structures of voluntary group action to achieve common objectives. Their growing numbers indicate that increasing numbers of people have seized the initiative to become agents of change within open political structures. Their vitality fuels democratic movements and protects civil liberties. Democratic systems themselves take many forms, even among more mature societies in the North.

The United Nations Development Program estimates that there are more than 50,000 NGOs in developing countries, with over 250 million people "touched" by their activities. Perhaps the greatest impact of PVOs and NGOs working in development is in the health sector, a reflection of their genesis, which was to rescue and provide relief in response to emergencies. Yet even these organizations have difficulty in reaching the very poorest members of society.

The skills PVOs and NGOs bring to health in development include: 1) efficient and appropriate health service delivery at the community level; 2) ability to reach some of the poorer and more marginalized in both urban and rural populations; 3) promotion of local participation; 4) rapid response to emergency situations; 5) capacity to articulate community needs; and 6) ability to develop innovative strategies which may then be more broadly replicated.

Strong effective NGOs are closely connected with other, complementary NGOs and to their communities. They focus on increasing their capacity to provide a limited range of services well. All are vulnerable to the vagaries of funding which limits program planning horizons to as little as 1 to 2 years. Prospects for financial sustainability are

dimmed by the poverty of the communities in which they are working. Their community-focus makes it difficult to reach national and international donors.

The potential contribution that PVOs and NGOs can make to supporting development by promoting health and democracy is determined by two major factors: the type of organization and its governance or management style. These factors, separately and together, determine program orientation, program resources and program sustainability. There are three principal categories of PVOs and NGOs: international, such as CARE and Rotary Club; intermediary, including the Bangladesh Rural Advancement Committee (BRAC); and grass roots, which are community-based and act as catalysts to promote change and/or as service providers. The category of organization generally relates directly to the capacity to access financial resources and the ability to promote development. Often, these organizations are linked through partnerships which bring a broader range of resources to development programs.

PVOs and NGOs are not inherently democratic in their governance or management style. Authoritarian organizations tend to be focussed on outcomes; participatory organizations may encourage, but not necessarily respond to input from staff and beneficiaries; empowering organizations promote broad involvement but retain ultimate responsibility for program outcomes and democratic organizations are openly accountable and fully responsive to their constituencies. The relationships between types of organizations and their form of governance are often functions of the number of years the organization has existed, the culture in which it operates, and the requirements linked to financial support.

Health-oriented organizations usually fulfill one of two roles: advocates for change, or service providers. The most effective advocates for change are often those which are primarily service providers and use their experience as the foundation for advocacy. In the process of working toward health reform, some NGOs may be perceived as threats to their governments because their advocacy challenges prevailing power structures.

Many PVOs play a critical role in transferring organizational and technical skills to in-country intermediate and grass roots NGOs. Efforts to move toward democratic processes within an organization are often paralleled by efforts of PVOs and NGOs to introduce democratic processes to the communities in which they are working. Save the Children (SCF), a major PVO, was among the first to introduce

concepts of participation and empowerment to development in Bangladesh. Their primary health care program made a strong impact on key health indicators. It did, however, prove unexpectedly difficult to develop ownership of the primary health care program among members of the Village Development Committee. Ten years after implementation, in 1985, the project still belonged to SCF, and not to the villagers themselves. By 1990, donor emphasis and assistance had shifted completely, away from participation and empowerment to, more simply, impact on health indicators. With this shift, the prospects for village ownership, and continuation of the program after the SCF phase-out are poor. "A PVO cannot expect a community to sustain contributions if the community believes it is not an active partner in management and selection of project priorities."

Participatory processes are slow and unpredictable. As SCF learned in Bangladesh, primary health care goals, with a single focus on increasing child survival rates and improving maternal health may dominate goals of participation and empowerment, key elements of democracy.

Donor agencies are learning that the processes they use to interact with PVOs and NGOs differ markedly from those they use with governments. The World Bank has begun to work with large PVOs and NGOs, awarding umbrella grants to reach grass roots organizations which the larger organizations administer. This process has done little to encourage honest, open dialogue and equitable interaction between the World Bank and local groups.

The Pan-American Health Organization (PAHO) has been more successful in treating local organizations as partners in development. The Inter-American Foundation has productively focussed on building local institutional capacity while supporting community mobilization. The Canadian International Development Assistance Fund (CIDA) program has continued to evolve and now works with local NGOs almost exclusively through Canadian PVO counterparts.

The Swedish International Development Agency (SIDA) provides an accurate case study on their efforts to integrate democracy and health in Kenya. Local village health teams worked with villagers to develop proposals that SIDA officials found frustratingly unorganized. The proposal development process itself was slow and cumbersome. When these proposals were reworked and rewritten by UNICEF, local officials felt disempowered and no longer interested in the proposed health projects.

Tensions arise in four areas when the values and priorities of PVOs and NGOs differ from those of funding agencies. "Product vs. Process" tensions, found between USAID and U.S. PVOs, have surfaced because of USAID's primary focus on empowering health indicators, while concurrently calling for sustainability. The potential to link health programs to participation has been foregone in the driving effort to achieve rapid, measurable results. Promoting community participation is time-consuming and outcomes often do not neatly coincide with USAID priorities.

"Clashes in the Community" occur when PVOs and NGOs attempt to work together at the community level, particularly when their values, as shown in their forms of governance, or management, differ. PVOs, with predetermined health programs interventions, may clash with local NGOs whose programs and processes respond to needs

identified by their communities. Clashes also occur when PVOs and NGOs compete against each other for limited donor funding.

Many governments regard PVOs and NGOs as, “Barbarians at the Gate,” threatening power structures and demanding program support. Governments may attempt to increase control over NGOs, an effort which may curtail effectiveness. Government officials may resent losing scarce skilled workers to the private sector, particularly when they earn higher salaries. Officials may increase efforts to impose control on NGOs if they find donors working directly with NGOs in order to avoid excessive government interventions. And, lastly, tensions arise when PVOs and NGOs are called “Into the Breach,” and givenresponsibilities with or without concomitant resources to fill gaps in service delivery caused by the retrenchment of the public sector.

Many PVOs and NGOs are skilled in empowering communities to identify their own health goals and develop strategies to improve their lives. The first challenge to USAID and other donors is to use these same open participatory processes in working with PVOs and NGOs who are intermediaries between donors and communities. The second is to develop broadly defined programs which provide enough program and funding latitude to promote and implement decisions made by communities themselves.

Introduction

In recent years private voluntary organizations (PVOs) and nongovernmental organizations (NGOs) have emerged as major collective actors in international development activities. Although PVOs and NGOs are not a novel social phenomenon, the proportions, scale and pace at which they have been multiplying and expanding, the functions and roles they are taking up, and their increased sophistication and capabilities represent new and significant trends in both the North and the South (Cernia, 1988).

Numerous PVOs and NGOs have sprung up in both developed and

developing countries and are active in either local or national interests in all areas of public endeavor. They have expanded their traditional orientation for relief and welfare into areas heretofore considered the domains of governments and multilateral institutions, and into programs focussing on sustainable development (World Bank, 1991). Today, PVOs and NGOs work in nearly every sector and many work directly in health in areas such as service delivery, advocacy and research, or in associated areas such as sanitation, family planning, and community development. Increasingly, NGOs and PVOs have become more organized, more vocal, and more aware of their powers particularly when linked together as networks or within coordinating bodies (Cernia, 1988).

This paper is based on a literature review, supplemented by project documentation and the authors' own experiences. Examples are provided for illustrative purposes only. This paper seeks to identify challenges inherent in working with PVOs and NGOs to promote both health at the community level while, concurrently, promoting democracy.

The paper begins by discussing the roles of PVOS and NGOs in contributing to civil societies. Three principal types of PVOs and NGOs working in health are delineated and linked to four dominant government/management styles. The strategies which are used by several donors in working with PVOs and NGOs are outlined prior to discussing USAID's approaches to including PVOs and NGOs in health programs. The final sections highlight some tensions and challenges inherent in working with PVOs and NGOs in programs developed to promote both health and democracy.

PVOs and NGOs in Civil Societies

A civil society supports the growth and strengthening of NGOs, enabling them to articulate and represent their interests and those of

their communities in policy-making processes. PVOs and NGOs in the North and the South have demonstrated their capacity to mobilize people into organized structures of voluntary group action to achieve common objectives (Korten, 1991). Mobilization has been catalyzed because of frustrations with inefficient or corrupt governments, poorly functioning markets, and private institutions which are unresponsive to the broader social ramifications of development. Mobilization has led to the reform of existing institutions and the creation of new ones (Morgan and Rau, 1993). The increasing numbers of PVOs and NGOs indicate that more people have seized the initiative to become agents of change within open political structures.

In his speech to the Society of International Development in June, 1993, USAID's Administrator Mr. Brian Atwood said, "At the grass-roots level, participatory development and democracy go hand in hand. Group decision-making promotes representation, consensus, and accountability. It legitimizes institutions, and encourages compromise and conflict resolution. With each success, the ground is prepared for further democratic practice. Empowered individuals become the driving force for free labor unions, free enterprise, and civil discourse. The rise of a civic society promotes rational choosing and rational planning. Democracy is not an obstacle to development. It is a key to development."

NGOs form part of a new, independent sector emerging in many countries. Their vitality fuels democratic movements and protects civil liberties. "Their work promotes citizen involvement at the local level and serves to strengthen representative democracy from the bottom up" (USAID, 1993).

Democracy represents a long process of political development, shaped by key participants. In the South, its forms are continually evolving along lines inspired by, but not necessarily duplicating, the more mature democratic systems of the North. Even within the North, there are many models of democracy. Perhaps the simplest and most relevant model for NGOs is "direct democracy," such as that practiced in Switzerland today. Rather than only voting for representatives who then make most major decisions during their time in office, Swiss voters directly vote on laws passed, laws to be introduced, and key issues which affect their communities and themselves. Local referenda clearly show what the people in each small canton want and how their taxes should be spent. This form of direct democracy requires participation by an educated, informed public who have a big enough share of material prosperity "to understand why they are responsible for their country's future" (Beedham, 1993).

In the South, those more educated and informed have begun to take active roles in promoting democracy. In Chile, for example, during the period from the 1970's to 1990, the NGO movement worked on two fronts to provide a focus for political opposition to the military government and to mitigate effects of poverty on marginalized populations. Popular education on democratic ideals along with active encouragement in participation in projects played key roles in the NGO strategy to keep democratic aspirations alive. When a democratic government was elected in 1990, the participatory approach the NGOs had fostered became an important aspect of government policy (UNDP,1993).

There is an extremely high level of heterogeneity among NGOs; however, most NGOs are constructive forces within their societies. Some NGOs may not yet share democracy's basic beliefs in the rights of the individual and value the rights of the tribe above those of the individual. NGOs in societies which have never practiced democracy may be prone to modelling their own governance and strategies for program development along more familiar authoritarian principles.

Impact of PVOs and NGOs

The numbers of PVOs and NGOs throughout the world are difficult to estimate. Currently, the Inter-American Foundation lists some 11,000 NGOs working in Latin America alone (IAF, 1991). The UNDP estimates more than 50,000 NGOs in developing countries worldwide (UNDP, 1993) and over 2,500 Northern NGOs and PVOs are currently registered in the OECD Directory of NGOs.

The growth in the numbers of NGOs (Korten, 1991) is parallelled by a similar growth in their influence and expertise. The stronger role that NGOs are demanding in policy making was clearly evident in the 1992 UNCED conference in Rio de Janeiro in June, 1992, and even more so at the Preparatory Committee II meetings in New York in May, 1993, in preparation for the International Conference on Population and Development in Cairo in 1994. At this meeting, NGOs were included as active participants in policy dialogue and all major discussions throughout the entire proceeding.

The UNDP estimates that over 250 million people in the developing world are "touched" by PVO/NGO activities. Yet NGOs affect less than 20 percent of the world's 1.3 billion living in absolute poverty. In Bangladesh, which has one of the largest and most diverse NGO sectors in the world, NGOs reach only 10 to 20 percent of the poor

and are likely to miss the poorest 5 to 10 percent (UNDP, 1993). In 1990, flows from PVOs and NGOs in the North to NGOs in the South of $7.2 billion, amounted to approximately 13 percent of the net disbursement of foreign aid and only 2.5 percent of the total resource flow to developing countries (UNDP, 1993).

Nevertheless, PVO/NGO impact on transferring monetary and technical resources to the developing world is significant. Of the $4.7 billion transferred to developing countries for the health sector in 1990, $1.1 billion (nearly one quarter) came by way of PVOs or NGOs (World Bank, 1993). Perhaps the greatest impact of voluntary organizations in development lies in the health sector, reflecting the genesis of international PVOs and NGOs, which was to rescue and provide relief in response to emergency situations.

Bilateral and multilateral development organizations are becoming increasingly aware of the significance and potential of PVOs and NGOs (Brown and Korten, 1991). As a result, these organizations have begun to include PVOs and NGOs in many of their programs. While these development organizations acknowledge the contributions that PVOs and NGOs have made and continue to make to the process of development, all are searching for optimal ways to work with them so that the benefits of their work are not lost, and the characteristics of their organizations not obscured by donor-driven priorities.

Strengths and Weaknesses of PVOs and NGOs

The newly recognized and valued role of PVOs and NGOs reflects the skills they bring to development processes, including: 1) delivery of services to people at the community level efficiently and appropriately; 2) ability to reach some of the poorer and more marginalized among both urban and rural populations; 3) promotion of local participation; 4) rapid response to emergency situations; 5) capacity to articulate accurately and persuasively the needs of the communities in which they are working; and 6) ability to innovate and adapt strategies which may then be replicated more broadly (Cernea, 1988; Clark, 1991; Dick, 1991; Frantz, 1991; Smith, 1989).

Based on two studies which included a total of 72 NGOs in Latin America, Carroll (1992) has identified six functional characteristics of NGOs which have made them strong, viable forces for development

Box 1

Types of PVOs and NGOs

Category	*Classification*	*Example*
I. International	a. PVOs	CARE
	b. Northern NGOs	Rotary
II. Intermediary	a. Regional	FAVDO
	b. Southern	BRAC
	c. DONGOs/GONGOs	SRN
III. Grass Roots	a. Commuinty NGOs	T A S O
	b. Primary	Unions

within their communities. NGOs with the greatest capacity to promote development have: 1) strong relationships with other NGOs; 2) the ability to work with organized beneficiary groups; 3) focus on a limited number of tightly connected projects within a well-defined territorial scope; 4) obtain institutional rather than project specific funding; and 5) use new funds to deepen and extend existing services rather than to initiate new activities.

PVOs and NGOs also struggle with their own limitations and weaknesses. Funding is identified as an immediate and pressing constraint by most NGOs. Because funding is often dependent on the political and economic aims and priorities of funding organizations, many NGOs are unable to finance either the type or scope of program they would like to implement. Moreover, NGOs are hampered by practices of funding specific projects with limited time frames rather than comprehensive programs over longer periods. NGOs find that their real planning horizons may be as little as 12 to 24 months, reflecting donor project funding cycles.

NGOs' potential to sustain themselves financially often is sharply reduced by the level of poverty in the communities in which they are working. Their limited budgets prevent them from obtaining the technical and managerial skills they require. Their small size, which allows them to be flexible and responsive, often limits the scope of their programming to their immediate area. Because their work is focussed on those they serve, they find it difficult to reach national and international donors (Smith, 1989). Many say that even when they do communicate with these donors, they do not have the ability to ask for aid, or write proposals, in a format that donors can use.

While there has been a burgeoning growth of NGOs in the past decade, many are institutionally weak and isolated. They have not yet learned to form consortia to improve communications among themselves, share lessons learned, or pool technical expertise (Minear, 1987). Where the success of a program depends on the energy and dedication of NGO staff, these programs cannot be replicated apart from that staff (Clark, 1991). Yet staff turnover is an ongoing problem because other organizations and agencies seek skilled workers, and can offer higher salaries than smaller NGOs can afford.

The impact of PVOs and NGOs on health and development is directly related to the type of organization, as determined by the latitude of funding and outreach, and, secondly, by the governance or management style within the organization itself.

Typology of PVOs and NGOs

The potential contribution that PVOs and NGOs can make to supporting development by promoting health and democracyis determined by two major factors: the type of organization and its governance, or management style. These factors, separately and together, determine program orientation, program resources,and program sustainability.

While a great deal of literature has been devoted to analyzing different types of NGOs and their relationships to each other within a society, a simple structure can be identified. (See Box 1) This includes international nongovernmental organizations, intermediary or indigenous organizations, and grass roots, primary and people's organizations which function at the community level.

All of these organizations belong to the "independent sector," or the "third sector," as they are neither public nor profit-seeking private enterprise. They are primarily value driven, and are committed to providing services, functioning as advocates for specific human needs, and/or providing for individual participation in their societies. (USAID, 1993; Hartigen, 1991)

International Nongovernmental Organizations

International NGOs includes both US PVOs and Northern-based NGOs with headquarters in the northern hemisphere and which support global development programs. The term PVO is used by USAID to denote "U.S. based charitable organizations that operate

programs overseas in developing and/or transitional societies" (US-AID, 1993; p. 3). Because the term PVO is so prevalent in the US-AID literature, we will continue to use the term "PVO" to refer only to U.S.-based international NGOs, and the term "Northern NGO" to refer to Northern, non U.S.- based organizations.

PVOs generally have a broad resource base, generally within the US, which includes both the public and private sectors. Many, such as CARE, the Rotary Club, and the Red Cross, operate with funding from multiple sources, including the US government, private foundations and individual donors. Some also receive multilateral support from UN agencies and the World Bank. Others, such as OXFAM, do not accept any government support. Most international PVOs and NGOs have strong financial bases which expand their outreach and impact, increase sustainability, and enable them to provide strong technical support to field programs.

Intermediary Nongovernmental Organizations

Intermediary or indigenous organizations are based in the South and operate at a regional or national level. Intermediary regional NGOs often link with other organizations within local regions, whole countries, or several related countries. They may not be directly in contact with identified beneficiaries but instead coordinate or channel resources, technical assistance, and/or personnel to smaller grass roots organizations, which themselves may be more isolated regionally, politically, or interms of experience. The Forum of African Voluntary Development Organization (FAVDO) is a regional umbrella organization with a strong network, primarily in West Africa. An intermediary national organization, the Bangladesh Rural Advancement Committee (BRAC), supports a broad range of development activities within Bangladesh. Both NGOs receive financial support from international donors, and, to a very limited extent, from their own governments and from funds generated from local program participants. Intermediary NGOs are often valuable counterparts for international PVOs and NGOs, frequently forming partnerships with them to channel services and resources to local networks or grass roots NGOs. (Carroll, 1992; Brown and Korten, 1991).

Two other types of intermediary organizations have recently emerged, also working in the South at a national or regional level. DONGOs, or donor organized NGOs, include local affiliates of international organizations. The Salvation Army and World Vision, for example, have scores of community based programs throughout the

Box 2

NGO Governance and Community Interaction: From Authoritarianism to Democracy

Community and/or Outcomes	Obey	Contribute Information	Share in Decision Making	Initiate actions; Responsible for
	I I	I I	I I	I I
Governance/ Management Style	Authoritarian	Participatory	Empowering	Democratic

Definitions

Authoritarian:	Expecting unquestioned obedience to directions, no concern for community priorities of staff input.
Participatrory:	Community input is sought, but mangement continues to make all final decisions; community and staff are dependent on management.
Empowering:	Communities and staff share in decision-making; management facilitates these processes.
Democratic:	Communites assess problems, determine and act on priorities; staff is self-governing.

Adapted from Rodriguez-Garcia, R. and Macinko , J., 1993 and Stewart, R. 1986.

South. DONGOs are often externally driven by objectives, projects and procedures determined by their headquarter staff in the North.

The second, government organized NGOs, or GONGOs, are developed by national governments in response to an institutional or service delivery gap which could be filled by an NGO. GONGOs, such as El Salvador's Secretaria de Reconstruccion (SRN), then exert influence and control in a particular sector within a country with the support of national governments and without fear of internal repercussions. These distinctions may appear minute, but they determine program focus, sustainability, accountability and relationships with host country governments, and with all other NGOs operating within a country.

Grass Roots Organizations

Grass roots organizations all function at the community level. This category includes both grass roots community NGOs and primary or people's organizations. Both are developed by their communities in response to needs perceived by the community. Both are therefore accountable to their communities. Community NGOs generally provide services and support to meet local needs. The AIDS Support Organization (TASO) in Uganda, for example, was developed by

local leaders to provide support services for persons with AIDS, and to educate communities about AIDS prevention.

Primary or people's organizations, the smallest aggregation of individuals or households which engage in development, often parallel grass roots organizations and have, as their central task, not service delivery, but the economic and political empowerment of the people. They are often generally democratic in their advocacy processes, becoming a training ground for democratic participation. They provide collective bargaining power for, and exist to serve their members. Because they are frequently self-reliant, their continued existence is often not dependent on outside initiatives or funding. These organizations include local unions and women's groups, such as the Self-Employed Women's Association (SEWA) in Bombay. SEWA has, in fact, managed to sustain its grass roots character while concurrently expanding to other communities in the region, and accepting support and technical assistance from international and intermediary organizations.

Other Structures

All three of these groups, international NGOs, intermediary NGOs and grass roots organizations may form consortia, or umbrella groups among themselves, working together to achieve common goals and protect their common interests. These consortia take many forms, and may be composed vertically, that is, among differing levels of NGOs to better channel resources or focus on a specific initiative or region; horizontally, among groups of similar NGOs, in order to disseminate information and to more effectively advocate their positions (InterAction, in Washington, D.C., represents more than 100 PVOs, and provides a political voice for many of its members); or in any combination of these two approaches. (Minear, 1987)

Governance of PVOs and NGOs

Both PVOs and NGOs, in their governance and management styles and in the processes they use in advocacy and servicedelivery within their communities, may practice the full spectrum of possibilities from authoritarian to democratic. (See Box 2) These complexities make generalizations very difficult. Some, particularly those which were established twenty or more years ago, continue to operate as autocracies, although, because of a wish to appear politically correct, they may now couch much of what they do in their work in communities as

being participatory. Others continue to be internally authoritarian while externally, at the field level, they promote participation. While many practice participatory approaches to development, fewer have the vision, or skills required, to move along the spectrum, toward democracy. Even those NGOs which promote democracy have found that empowering processes are not sufficient as ends in themselves, but must be linked to concrete programmatic achievements in order to be sustained (UNDP, 1993). Organizations which are fully democratic and autonomous are fewest in number and, judging from the literature, are found most frequently in Latin America.

Generally, an NGO's form of governance or management reflects its organizational values. Those which are authoritarian are often more focussed on outcomes than on processes, with staff work regarded as simply a means to an end. Programs are designed from the top and information flows only one way. Staff members usually work alone with little opportunity for teamwork. They seldom understand or contribute to overall program development. These organizations excel in reaching externally determined targets within a given time period. Their capacity to sustain staff interest and productivity over an extended period of time is usually limited.

Organizations which are participatory encourage input from their staff and from their beneficiaries as information begins to flow from the bottom to the top, paralleling top-down information flows. While staff and beneficiary counsel is sought, and included in decision-making processes, it is not necessarily acted upon. On the grounds of possessing greater wisdom and more knowledge, organizational heads may protect staff and beneficiaries alike from the consequences of their input by acting upon it selectively.

Empowering organizations involve staff and communities in all stages of program design and implementation. The NGO staff retains leadership and has ultimate responsibility for program outcomes. Frequently, the initiative for programs is external, outside the community itself, but supported by the community because of derived benefits. To date, relatively few of these organizations have articulated the fact that, through the process of empowerment, they are introducing the basic concepts of democracy.

NGOs which are governed by democratic processes tend to be transparent, accountable and responsive to their constituencies (Hirschman, 1991). These three characteristics allow them to mobilize individuals and engender ownership among these individuals of development strategies, particularly in health programs. This in turn

engenders empowerment and promotes sustainability. In these organizations, the value of each contribution is weighted equally. Organizations are more self-directed and responsibilities for inputs and outcomes are more equally shared. Participants are encouraged to be knowledgeable about democratic systems and local issues and are expected to exercise judgement responsibly. Participants also recognize that while this process is inclusive, it is not flawless. Progress may be halting but it may be more durable. These organizations are learning to take responsibility for themselves and their programs.

Transitions in governance from authoritarianism toward democracy may be slow and difficult. While donors can support this transition through their financial and technical assistance, it may be short-lived because old leadership cannot fully adopt the values inherent in democratic systems. Conversely, donors may not be ready to support the full evolution of NGOs, and NGOs may surge ahead of donors in their process of transformation.

Donors may seek more compliance and less independence from the NGOs they are working with in development programs. The World Bank, for example, calls for a participatory approach in working with NGOs and defines participation as “a process by which people, especially disadvantaged people *influence* decisions which affect them.” Concurrently, the African Charter for Participation and Development, written in Arusha, Tanzania in 1990, uses a more advanced definition of the role of NGOs, which includes “empowerment of the people to effectively involve themselves in creating the structures and in designing the policies and programs that serve the interests of all as well as to effectively contribute to the development process and share equitably in its benefits [sic]”.

In his study of 30 NGOs working across the spectrum of development activities in Latin America, Carroll (1992) shows that each scored well in service delivery, in reaching the poor, in adapting innovative methods for service delivery, and in promoting local participation in projects. Moreover, a recent Dutch study -- with evidence from Brazil, Burkina Faso, Chile, India, Indonesia and Zimbabwe -- concluded that NGOs which practiced participation and community involvement had broadly increased empowerment. The report indicated that people in target groups now “... act more often as partners in discussions with organizations outside the village, have the courage to lodge complaints with civil servants of the local government, move freer and travel more. These are seemingly small changes but of essential importance for the people themselves” (UNDP, 1993).

A clear example of an international organization which embodies these attributes is the International Federation of Red Cross/Red Crescent Societies and its national affiliates. At the national level, Red Cross/Red Crescent organizations' principles of appropriateness and equity, combined with their community-based approach contribute to the development of strategies used in the face of disaster. Local staff in collaboration with NGOs in the region identify priorities and obstacles which may impact on national preparedness plans and develop preparedness plans accordingly. As Dick (1991) observes, coordination with governments to develop consensus on services and standards is on-going. "NGOs have proved their worth in developing new initiatives and innovative programs in the field of disaster preparedness and response."

Relationships Between Types of Organizations and Governance

The relationships between the types of organizations (international, intermediary or grass roots) and their form of governance (authoritarian, participatory, empowering, or democratic) are often functions of the length of time the NGO has been in existence, the sources of financial support and the related accountability required, exposure to democracy, familiarity with management theory and concern for program impact and sustainability.

International PVOs and NGOs are represented at all points on the continuum from authoritarian to democratic governance. Those which have been established longer are more inclined to perpetuate authoritarian management styles within their own institutions. Most, however, have adopted participatory approaches to their health and development programs in the field,because of a desire, or donor-driven demand to promote sustainability. These organizations recognize that empowering and democratic approaches to program development and implementation may not, ultimately, meet specific pro-

grammatic objectives as defined by funding agencies. Prudence therefore determines the degree of empowerment these PVOs and NGOs support at the field level.

Intermediary organizations, particularly regional and national NGOs, are primarily accountable to the NGO networks and constituencies they serve, and therefore are more likely to promote participative and empowering approaches to development. A broad base of financial support and multiple institutional linkages with multilateral and bilateral agencies, national governments and local peoples may provide the latitude required for NGO leaders themselves to determine priorities and design health and development programs accordingly. But even among intermediary NGOs, internal governance may closely parallel patterns found in international NGOs. In addition, DONGOs and GONGOs may find difficulty in moving beyond a participatory approach to self-governance or greater community involvement because of discrepancies between demands by donors and governments on one hand, and local communities on the other.

Grass roots organizations, because they are generally locally generated, supported and focussed, may have the greatest potential to promote both health and democracy within their communities. And if a community determines that its current development priority is education, or water supply, programs can be quickly refocussed, and, with effort, appropriately redesigned. The locus of accountability and responsibility lies within the grass root organization, which is primarily accountable to the community itself.

While NGOs in Latin America, Asia and Africa incorporate varying degrees of democratic governance, NGOs in newly emerging democracies, particularly those in Eastern Europe and the former Soviet Union, currently have much greater difficulty in doing so. They are newer and financially fragile. Leaders have often only vague concepts of the nature and functions of NGOs. Values and behaviors ingrained for seventy years under communist systems are transferred in their entirety to these fledgling organizations. Governance is authoritarian; interaction with other members of the organization is limited; information is guarded; and transparency is tightly controlled. Concepts of participation and empowerment are poorly understood. Yet new political openness has provided opportunities for NGOs to emerge.

Box 3

The Orangi Pilot Program: A Catalyst for Community Participation

One of the better known projects of the sort is the Oranji Pilot Project (OPP), organized by Akhter Ahmeed Khan in the Oranji suburb of Karachi, Pakistan.

Originally a spontaneous settlement area which grew up without municipal services, this large community lacked adequate drainage systems and water supplies, which let to recurrent epidemics, and high infant and child morbidity and mortality. In 1981, OPP conducted research which undercovered reasons for the relative passivity of the inhabitants towardf their appalling living conditions. Once these obstacles were understood, OPP worked systematically to address each, and set up teams of social organizers and teams of technicians to develop work plans for construction.

Between 1981 and 1986, "about 28,000 families joined the low cost sanita- tion program, constructed underground sewerage lines with a total of over 426,000 feet, built secondary drains, introduced over 28,400 sanitary latrines and have themselves invested close to 30 million rupees in this development." This NGO provided services which the municipality could not financially or organizationally support. OPP has improved the quality of life of the people of Orangi and provided a valuable model on community organization for replication by other NGOs (Cernia, 1988).

Democracy and Health

Health-oriented PVOs and NGOs usually fulfill one of two roles: advocates for change, or service providers. Because NGOs recognize and respond to community needs easily and quickly, and because multilateral and bilateral agencies have focussed many of their programs on community-based health interventions, there has been a proliferation of NGOs delivering health services. Fewer NGOs are active as health advocates. All service delivery NGOs do not have the ability or the will to include advocacy as part of their programs. In fact, this dual role is, in many instances, not desirable, given increasing needs for services and the possibility that advocacy may be introduced at the expense of service delivery. However, those NGOs which are primarily focussed on service delivery and which have the institutional strength and capacity to become advocates, have found that their credibility and therefore effectiveness as advocates, is very high when they do participate in policy fora.

PVOs and NGOs as Policy Advocates

"Two decades of primary health care experience in many Third World countries has created a strong grass roots constituency and a strong political force" (Morgan and Rau, 1993). NGOs have demonstrated their ability to participate in policy development processes at the multilateral level. An example of participation in policy processes is unfolding in the preparatory processes of the International Conference on Population and Development (ICPD). In May, 1993, NGO leaders challenged the concept of development as a purely economic issue and urged UNFPA to give greater priority to human concerns. Theysuccessfully lobbied to have UNFPA include policies on the status and rights of women and the status of the girl child within the framework of 1994 International Conference on Population and Development. These leaders, many of whom led service delivery organizations, knew little about advocacy. Until this meeting they had not conceived of themselves as being able to contribute to policy making processes. They required focussed technical assistance to master the issues before them and the strategies they needed to adopt in order to be effective advocates. With this assistance, they became skilled and powerful contributors to on-going policy discussions.

Effective advocacy also impacts communities themselves. In Nepal, for example, one small area, Jumla, has benefitted from an extraordinarily successful child survival program, first implemented in 1986. This program is the only visible community-level health service in the area. Employing local farmers as service providers on a temporary basis, the project has had measurable effectiveness in lowering formerly extremely high levels of infant and child mortality. This program focussed on service delivery, education and participation. As villagers were educated, the local NGO leaders encouraged their increasing involvement in decisions which defined the project. And as they became more confident of their ability to recognize needs, advocate for them and implement them, their participation grew to empowerment. When the program's existence was threatened by national leaders, the community leaders mounted a policy initiative to continue the program. The Nepali government has now begun to place greater emphasis on providing health services to remote, under served populations and less on more centralized and less accessible tertiary care (Daulaire, Nils, personal communication 1993).

NGOs in Mexico, Costa Rica, the Philippines and Bangladesh have also struggled to make their nation's health programs more responsive and accountable to the communities they serve (Abed, 1992; Laurel, 1989; Morgan and Rau, 1993). Most of these NGOs have continued to be community-based, and focussed primarily on service

delivery. By linking advocacy to services some have effectively improved health within their communities. Others have experienced conflict between competing demands for time and resources as advocates and as service providers. New and institutionally fragile NGOs may not be able to do both effectively.

Many NGOs have strong track records in promoting change through advocacy and education within their communities as an integral component of health programs (See Box 3). A World Bank survey of its health, population and nutrition projects evaluated between 1981 and 1987, found that 59 percent mobilized grass roots organizations to serve as channels forpromoting acceptance of new health strategies through education. The Bangladesh Rural Advancement Committee (BRAC), for example, before implementing a community-based immunization program, found that it first had to educate community members about the value of immunizations to improving health. BRAC then moved to help community members advocate for access to immunizations to local authorities. (Abed, 1992) By educating the community on the value of immunization and advocacy for services, BRAC built up the community's capacity to take control of one aspect of its own health care and to participate in local decision-making processes.

Potential for Backlash

In the process of working for health reform, some NGOs which have a primary focus on advocacy have become perceived as threats to their governments. NGOs working in health, especially health care for the poor, often become involved in political struggles because the factors impeding health are often clearly influenced by political processes. Advocating change in health care is often advocating change in the dominant political system. In Argentina, for example,

Box 4

North/South Partnerships: The Katalysis Model

Leaders of the PVO Katalysis realized that: 1) traditional, northern-dominated "top -down" assistance had failed to provide sustainable improvement in the lives of the poor; 2) the interdependent nature of complex problems facing developing countries demanded a collaborative approach to problem-solving; 3) the South's right and ability to control its own development is increasingly critical.

Programs are based on the needs, desires and input of the local people. Beneficiaries choose and pay for services rendered, and the benficiaries participate fully in the design and mangement of their development projects. The relationship is that of equals. As clients, the beneficiaries are responsible for setting the agenda, establishing priorities, and paying the negotiated fee. They also have the power to fire or terminate their contracts for services.

The management style is also unique. The Katalysis Board regularly exchanges seats with the boards of the Southern partners. Katalysis has the ultimate policy- making authority in its own affairs, while the Southern boards have the final say in operational matters in their own countries.

The democratic link is therefore on three levels: First the NGOs have a democratic, transparent and responsive relationship with their populations. Second each individual NGO has a board of directors and a democratic decision making structure, based on their own cultural, historic and personal experiences. Third, the PVO-NGO donor client relationship is also democratic, with all partners contributing to the mangement and decision making on development programs and other initiatives.

This type of partnership is resource intensive. However, the participants believe that it is the only way to produce sustainable participatory institutions which will continue to meet the development needs of the people the organizations are serving.
The USAID final evaluation supports this conclusion (USAID, 1993).

the Panos Institute has found that NGOs advocating for the rights of persons with HIV to care were the same NGOs that were working with people who had "disappeared". These advocates were the social activists who organized communities, sought social change and challenged governments' accountability.

Organizations involved in health issues may be perceived as such threats to governments that they are forcefully put down. In Mexico, workers formed a union to fight for healthier working conditions and for fairer employment practices. But the same factors which impeded union democratization also prevented improvements in the workers' health. Although there was broad participation in the union, the members did not have enough strength to counteract the joint action of management and the state-controlled union leadership and attempted reforms were squashed (UNDP, 1003; Laurel, 1992).

In countries of the former Soviet Union, local communities have only recently become fully aware of the extent and severity of pollution in their immediate environments. Ukraine and Kazakhstan have both seen political groups formed around issues of environmental health. In Ukraine, the impact of Chernobyl is so pervasive and devastating that health is now an issue which unites people, regardless of political orientation. In Kazakhstan, where the impact of nuclear accidents is now openly recognized, health has the potential to become a rallying point for dissent. There are well-grounded fears that the current political structure may be threatened by these health advocates.

Even local health committees, organized to support community health interventions, can become advocates for new social order. Costa Rica's rural health program, which ended in 1982, received its greatest impetus from the Alma Ata Conference in 1978. This conference placed a major emphasis on community participation. But community participation was regarded as potentially dangerous by the political elite. One local health committee analyzed each infant death and concluded that infant mortality was associated with poverty and unemployment. This led them to demand more jobs, a demand which the local elites recognized as threatening their privileges. Morgan writes that international support for participatory community projects was withdrawn as "bureaucrats from many governments were trying to persuade WHO and UNICEF to abandon community participation because it precipitated political instability." Soon, com-

munity participation programs in Costa Rica gave way to selective primary health care. (Morgan, 1990).

PVO-NGO Linkages in Promoting Democracy and Health

Many PVOs play a critical role in transferring organizational and technical skills to in-country intermediate and grass roots NGOs. The capacity building, networking and advocacy skills mastered by many PVOs are the same skills required by NGOs involved in promoting democracies. Many PVOs actively seek to transfer technical skills and responsibilities to local NGOs. Others, particularly those in relief work, place greater emphasis on obtaining results than on transferring skills. Some have modified their initial emphasis on relief and now focus on building local capacities. An excellent example of a participatory approach to development which has promoted ownership and empowerment is found in the work done by Katalysis, a young PVO based in California. Their matching grants from USAID have enabled them to strengthen southern NGOs through a unique approach to transferring technical assistance. (See Box 4)

Introducing Democracy in the Community

The efforts to move toward democratic processes within an organization are paralleled by efforts of PVOs and NGOs to introduce democratic processes to the communities in which they are working. Save the Children (SCF), a major PVO, was among the first to introduce concepts of participation and empowerment to development work. SCF developed their community-based, integrated rural development (CBIRD) program between 1972 and 1978, a redirection from their earlier concentration on specific projects (i.e. housing, irrigation) toward a focus on the process of community involvement. When SCF introduced this approach in Bangladesh, the goal was to develop a community-based program in which villagers “of diverse class, religion, and sex, would participate together to improve their social and economic living conditions.” The key component of CBIRD planning in Bangladesh included community participation and transfer of responsibility to Village Development Committees. Project

orientation evolved away from a specific focus on projects toward a focus on the processes of community involvement.

This integrated, horizontal development system included village authorities who coordinated activities in all major sectors. Villagers elected a Village Development Committee (VDC) in each identified "impact area". VDC members were required to represent all members of the community, including the poor, landless and women.

Early in its experience, SCF found that if all VDC members were elected, the VDC was dominated by the powerful families, primarily because of the patron-client relationships found in rural areas. This purely democratic system, in fact, distorted community representation. In order to reduce this domination and make the VDC more representational, SCF introduced an alternative practice, whereby eight of the 15 VDC members were elected, (each of 4 sectoral subcommittees elected two), seven were selected by SCF, and three of the 15 had to be women. This process was introduced to improve the quality of community participation, to minimize factional rivalries between social, political, economic and religious groups and to raise the subordinate status of women. Broad community participation was encouraged whenever possible to promote ownership and empowerment. All VDC offices and health clinics were built on land donated by villagers, who also donated their time and labor for construction. Roads and bridges were also built by volunteers.

Concurrently with several other programs, SCF introduced a primary health care program. The impact was remarkable. By 1985, the percentage of women who practiced some method of contraception was almost twice the national level. More than 90 percent of women could demonstrate the correct way to make and use oral rehydration solution. Growth monitoring was done efficiently and remedial steps were utilized when appropriate. The crude death rate in the SCF impact areas, all of which had been selected originally because the health indicators were so poor, was 10/1000 compared to a national average of 18/1000.

Participation and empowerment were theoretically operative but SCF itself doubted the capacity of the communities to sustain this progress apart from their presence. As early as 1978, one village was considered by SCF to be approaching self-sufficiency and therefore ready to phase itself out of CBIRD activities. This was verified again in 1981. By 1985, at the time of this evaluation, SCF still had no concrete plans for phase-over. It had taken more than ten years for SCF to develop the program to that point. While the people may

have owned the land for the clinics and VDC offices, and elected their own representatives, SCF, and not the Village Development Committee, still owned the program (Danforth and Zaman, 1985).

Democracy or Health

"We went to the village to ask what they wanted. They said--give us an improved water supply. We asked what else? Theysaid--a hospital. We asked what next? They said--a school. All the time, in the backs of our heads, we knew they were going to get maize production" (Mason, 1987). The practice of asking when coupled with responsive actions, is part of the process of encouraging participation and empowerment. But when questions are asked and the responses disregarded, the outcome is less positive.

One of the strengths of the Child Survival program has been its effectiveness in rapidly lowering infant and child mortality rates. When the SCF project in Bangladesh was again evaluated in 1990, following the earlier evaluation in 1985, the key Child Survival strategies were found to be correctly and broadly utilized. These interventions were credited with lowering the infant mortality rate (IMR) from 129/1000 in 1984/85, to 108 in 1988/89. The child mortality rate (CMR) had dropped from 12.8/1000 to 8.9/1000 over the same period. And 36 percent of the population was using modern methods of contraception, twice the national average for rural Bangladesh. The project was a model for effective community-based child survival interventions.

This evaluation, however, does not mention the strategies for community ownership and empowerment that had been carefully documented in the report written five years earlier. Donor support had shifted toward quantifiable indicators of health. Indicators of process, which had been discussed as early as 1981 were, by 1990, neglected. A single focus on health, as defined the Child Survival program, had replaced the more comprehensive CBIRD approach originally developed to promote community participation and empowerment. The Village Development Committees, which were credited with helping to achieve these remarkable improvements in health, were still not sufficiently empowered to take over full responsibility for the program. Although SCF had extended their planned phase out program by 7 years, to 1997, evaluators were not confident that the child survival interventions would, even then, continue beyond that time. And they recognized that phase-out by SCF would mean that "health for all will not be equal health for all" (USAID mimeo, "CS4

Midterm Evaluation"). The focus on strategies with measurable indicators had left little scope for promoting local decision-making about health priorities. Rather than empowerment, these strategies had created dependency.

The USAID supported "PVO Child Survival Technical Report" (April, 1993) reflects the challenges which arise when the goals of democracy and health are linked. "Community participation, although frequently cited as part of a PVO's sustainability strategy, has not been as effective as it could be in empowering communities to take greater responsibility and control of their own health....A PVO cannot expect a community to sustain contributions if the community believes it is not an active partner in management and selection of project priorities."

The Child Survival program provided a limited range of health interventions which had a pronounced impact on infant and child health. Community ownership of the program was sought to promote sustainability of the program itself, rather than supporting empowerment. But, because it had not promoted empowerment, project objectives of sustainability were jeopardized. Beneficiaries were not encouraged to design their own programs because there were actually very

few options available. The program echoed the options presented to customers buying Henry Ford's Model "T". They could have any color they wanted as long as it was black.

The question arises - who is really prepared to fund community-identified health priorities? If Child Survival funding is dependent upon a program's ability to demonstrate a significant impact over a given period of time, within cost parameters, community-directed programs are full of risk. Participatory processes are slow and unpredictable. They may result in programs which are neither a camel nor a horse.

Hirschman (1991) observes that "Democracy is also to be valued as an end in itself because it is more likely to provide scope for the exercise of individual judgement and initiative, the fulfillment of individual potential and social justice." How compatible are "individual judgement and initiative," fundamental components of democracy, with primary health goals? As illustrated in the example above, a skilled and resourceful PVO found that processes designed to promote democracy were initially compatible with those processes designed to promote empowerment and sustainability of community-based healthprograms. In this instance, introducing democracy and primary health included education for all villagers in health and process issues, and the introduction of community-based decision-making processes which encouraged equal participation. Villagers supported community participation, planned strategies, elected leaders and committees, and encouraged debate and compromise, all key aspects of both democracy and primary health care. However, as the program continued to evolve, it became evident to SCF that the two goals of health and democracy could not be attained to the same degree at the same time. Ultimately, one had to take precedence over the other. Because donor priorities were focussed on health, with its measurable inputs and quantifiable outputs, and because SCF was accountable to its donors, USAID, the health program dominated.

Multilateral and bilateral development agencies fully recognize the challenges inherent in working with and through PVOs and NGOs to promote health at the community level. Because health programs have placed high priority on improving sustainability by introducing participatory and even empowering strategies to project design and implementation, these programs have also introduced elements of

democracy. As illustrated below, development agencies have taken many different approaches to promoting health through participation and empowerment. Each approach, however, reveals weaknesses as well as strengths.

Multilateral and Bilateral Strategies for Working with NGOs

Donors recognize the value of supporting NGOs which provide services, because NGOs are able to interact within communities more quickly, efficiently and responsively than the public health care delivery system. NGOs also introduce innovative approaches at the community level which, if successful, can be replicated on a broader scale by the public sector.

Most donor agencies have recognized that the processes they use to interact with NGOs need to differ markedly from those they use with governments. These processes may have a profound impact on the effectiveness of NGOs and their ability to provide people-centered health care which is responsive to local needs.

There is no single, best approach to working with NGOs. The strategies donors have developed reflect their own priorities. Most strategies have been designed to avoid several potentially negative outcomes. First, donors have begun to recognize that they may, knowingly or unknowingly, force NGOs to adopt donor priorities, at the expense of those of the NGOs and their constituencies (World Bank, 1991). Donor-NGO relationships can re-orient the NGO to becoming a specialized service delivery organization with a primary concern for the quantity and quality of donor prescribed services, and allow little or no latitude for responding to local priorities or the development of innovative service delivery strategies. Under these circumstances, NGOs risk compromising their political autonomy and credibility as representatives of the people. Second, donors who provide assistance to NGOs through the national governments may also support government oversight and control, reducing the effectiveness of NGOs at the field level (World Bank, 1993).

Recognizing these possibilities, donors often work through regional and national NGO consortia and networks rather than working through host country governments. These networks have shown

they can develop the type of interface necessary to deal with multiple donors and community level NGOs. They can also channel resources and technical assistance to local NGOs in a more appropriate and responsive measure than their governments can. Donors have themselves recognized that they can help establish enabling environments for NGOs by encouraging governments to work with NGOs, either directly or through representative network organizations, in all phases of national policy planning, design and implementation. In addition, they may model their support for popular participation by including NGOs in developing their own assistance programs.

The World Bank

The World Bank has generally utilized PVOs and NGOs as implementing agencies for community level interventions. In an effort to support the work of local NGOs, the Bank has developed several small grants programs in which it awards a relatively large umbrella grant to one PVO or NGO, which in turn makes small grants to local NGOs. This one organization is accountable to the Bank for effective program development and administration of funds. By using PVOs and NGOs as intermediaries, the Bank has attempted to provide support to grass roots and people's organizations which is responsive to local priorities. Their approach has done little to encourage honest, open discussion and democratic participation between the Bank and umbrella organizations and in-country NGOs and their constituencies. It does even less to encourage self-reliance and experimentation with new approaches to development assistance, and the capacity of NGOs to contribute to policy dialogue has remained unrecognized.

This is substantiated by the NGO Working Group Position Paper in 1990, which urged the Bank to be more supportive of popular empowerment, more equitable relationships with partners, and more open decision-making. In 1991, the Bank began to review experiences with participatory development within and outside the Bank and disseminate funding throughout the Bank. In an attempt to mainstream participatory approaches to development, the Bank is also preparing a handbook as a guide for staff members. The country level NGO views are included on proposed projects and policy reform efforts, but much remains to be done (InterAction, 1993). Individuals within the Bank continue to make great efforts in this direction, but the scale of Bank operations precludes most forms of equitable inter-

action.

As an organization, the Bank appears to have only limited concepts of the potential for PVOs and NGOs to develop and deliver sustainable, community-based health care programs. To illustrate, an overview of the latest World Development Report entitled *Investing in Health* does not articulate any coherent strategy for utilizing NGOs. In fact, the role of NGOs is mentioned only in passing, in relation to service delivery (World Bank, 1993).

Pan-American Health Organization (PAHO)

The Pan-American Health Organization (PAHO) has developed a transparent, accountable and relatively democratic approach to working with NGOs in Latin America. One particular project is designed to facilitate communication and cooperation between local governments and NGOs. It seeks to promote interventions in areas in which NGOs with expertise in health and development can collaborate with governments in the design and implementation of projects, each bringing its own comparative advantages to the process.

PAHO considers NGOs to be partners with governments in fostering development. These partnerships help link the broad objectives and policy tools of government ministries to support for community-based, registered NGOs. Through these links, governments find they can coordinate health and development programs more effectively. In addition, this approach encourages NGOs doing similar work to pool their resources, talent, and information to improve the quality and effectiveness of their programs. And NGOs are encouraged to introduce programs in areas in which the government is unable or unwilling to intervene more directly.

Inter-American Foundation (IAF)

The Inter-American Foundation (IAF), funded by the U.S. government, also works directly with NGOs in Latin America. Respecting the political autonomy and financial accountability of the NGO's they fund, the IAF maintains a great deal of latitude in developing appropriate ways to build institutional capacity while supporting community mobilization. They have simplified grant making procedures and systems of accountability, thereby minimizing administrative responsibilities that NGOs find burdensome and expensive.

Canadian International Development Assistance (CIDA)

As early as 1975, the Canadian International Development Assistance (CIDA) program established a separate division designed to support international NGOs which were engaged in strengthening local NGOs. By 1989, more than 10 percent of Canada's overseas development assistance support was channeled directly to developing country NGOs. More recently, CIDA has refined this approach by recognizing that technical assistance to NGOs would flow at a more manageable pace and level if it were handled by Canadian PVO counterparts working directly with local NGOs (World Bank, 1993).

CIDA's NGO division supports three main types of organizations. The first category is that of Canadian PVOs. Canadian PVOs are funded by CIDA to collaborate with their partner NGOs in developing countries. Project plans are generally conceived and implemented in the developing countries by local organizations or through the PVO's field offices. CIDA provides funds for development activities to supplement funds raised by Canadian PVOs from the Canadian public. PVOs retain the initiative and responsibility for their programs. CIDA co-financing does not normally exceed CD$ 50,000 in the first year. PVOs which do not have long-term experience with CIDA are encouraged to undertake initial projects with another Canadian PVO which has already established a relationship with CIDA.

The second category is that of international NGOs and foundations. CIDA directly supports international bodies which work to strengthen other NGOs, such as the Asian Institute for Rural Development and the International Planned Parenthood Foundation. This support is similar to that used with Canadian PVOs, although it may not always involve local fund raising by PVOs.

The third category funds local, in-country NGOs directly. NGOs can obtain support from CIDA through three alternative approaches. The preferred method is channeling their requests to a recognized Canadian PVO, which then assumes the responsibility of submitting the project to CIDA. NGOs in developing countries may also approach local Canadian diplomatic missions to apply for the Mission Administered Fund (MAF) which finances small projects and provides technical, educational or economic assistance. Projects are approved at the discretion of the Head of Mission and do not exceed $CD 50,000. Local NGOs which do not have links with Canadian PVOs contact the Canadian Council for International Cooperation (CCIC), a coordinating body for many Canadian PVOs. CCIC also publishes regional

and sector specific PVO directories.

CIDA has established funding criteria which encourages partnerships between PVOS and NGOs for developing sustainable projects which are “developmental rather than relief or welfare oriented, deal with the causes rather than the symptoms of the problem, respond to the needs of the local people, and involve these people in the planning and implementation of the project itself” (CIDA, 1986, p. 12).

Finally, CIDA views support for NGOs and community development organizations as highly valuable in building a sound, popular basis for democratization. CIDA considers NGOs to serve as schools of democracy, teaching their members the value of free expression, compromise and political action. CIDA recognizes that NGOs build foundations for a culture of democracy, in addition to serving more traditional development purposes such as health and education. For this reason, CIDA claims to channel a larger share of its total over-seas development assistance through PVOs and NGOs than any other major development agency (Payne, 1992).

Swedish International Development Agency (SIDA)

SIDA is currently experimenting with one of the more advanced approaches to integrating democracy and health in three districts in Kenya. Begun in 1990, this four year project completed its mid-point evaluation late in 1992. The critical aspect of this model is community involvement from the earliest planning stages and in every stage of implementation. In this model, local district health teams of six to ten members went to each village in their area to discuss with the villagers their health priorities. The teams, instructed to start with small projects, had also been advised that not all of the resulting projects would necessarily be successful. Program success was defined in terms of relevancy to critical community health problems, cost-effectiveness, including the value of contributed labor, and sustainability through community participation and community investment in low cost construction components. Failure was tolerated as long as the processes of participatory discussions were followed. The health teams, with villager participation, developed proposals for community health programs which were then presented, through the Kenyan government, to SIDA for funding.

The proposals which resulted from this process were highly detailed and very unorganized. SIDA officials were frustrated at having to sift through the documents they had received in order to discern the essence of each proposed project. The process of reaching a consensus by both the health teams and SIDA on what was to be done was slow and cumbersome. The mid point evaluation found that the program was, “going well under the circumstances...and stands a good chance of reaching sustainability in the long run.” The report also states that primary health care efforts, “should be considered in a long term perspective and...given time to develop and grow” (Holmgren, et al., 1992, p.1). Although this is a four year project, it is already apparent that a time frame of more than 4 years will be required to reach program objectives.

The proposals that SIDA was able to fund were handed over to UNICEF. UNICEF field staff rewrote the proposals to make them conform more closely to UNICEF priorities. This rewriting, while constructive for UNICEF purposes, had a negative impact on the villagers. They felt disempowered by the rewriting process and did not recognize the work as their own. As Dahlgren reports “the locals lost the feeling for it” (Dahlgren, personal communication).

The Norwegian Development Agency (NORAD) implemented a simi-

lar program among the Turkani peoples of Kenya. In this program, health teams spent days in discussion with the people, working to educate them and help them to define their own needs. NORAD developed a program to train the trainers, who then worked with these local health teams, training them to interview the people and to monitor project progress. Unlike the SIDA program, the Turkani had to support most of the monetary costs of the program themselves. While there has not yet been a final evaluation of this program, Dahlgren speculated that the very limited amount of monetary support provided by NORAD for the program will likely deter its success.

Tensions in Working with PVOs and NGOs

While PVOs and NGOs bring skills and resources to health programs, they also bring values and priorities which may differ among themselves and from those of donors or host country governments. Differences among these four groups may create potentially destructive tensions. Tensions are most likely to arise when organizations working together differ in type as well as in governance. These differences may make it improbable that they will share a common goal for health programs or strategies for implementation.

Tensions Between USAID and PVOs: Product vs. Process

USAID is now in the process of defining an agency-wide approach to working with PVOs and NGOs. The challenge is especially complex for USAID because there are two separate but linked constituencies: American PVOs with their own health and development goals, their own private funding bases and their own political constituencies; and Northern NGOs, which are equally accountable to their own donors and program beneficiaries, in addition to intermediate and grass root NGOs. While PVOs with funding from USAID are working in many sectors, those working in health are most numerous and have the greatest impact at the community level.

USAID's objectives for health programs have been clearly defined. In her testimony before the Subcommittee on Foreign Agriculture on July 20, 1993, Acting Assistant Administrator Ann Van Dusen stated that:

> *A.I.D.'s strategy in health has been to focus on a limited, manageable mix of low cost interventions which have a direct impact on reducing mortality. The four main interventions involve: increasing immunizations; extending the use of oral rehydration therapy; reducing high risk births and improving maternal health; and improving nutrition among young children...*
>
> *Child health programs strengthen....institutional development at the community level: the mothers club in Bolivia, the Rotary Clubs in India, the local research and advocacy groups like the Child Health Institute in Haiti....*
>
> *PRITECH, a child survival project, has developed a small grants program for local NGOs to help them integrate oral rehydration therapy into community development.*

USAID's health strategy has clearly had a demonstrable impact on target populations. Infant and child mortality and morbidity rates and maternal mortality rates have been measurably reduced, as previously shown. In the drive to be accountable for funding, and answerable to Congress, however, PVOs funded by USAID have been forced to place more emphasis on health interventions, which have quantifiable outputs, than on processes designed to promote participation and empowerment. Community involvement in defining priorities has been sharply curtailed by USAID-defined health programs.

Child survival strategies brought to these villages do include a measure of participation, principally to enable the program participants to apply proscribed interventions, but also to promote sustainability. However, the potential to link health to participation and empowerment was foregone in the effort to achieve rapid and measurable improvements in health.

USAID has developed a strong Child Survival grants program with PVOs, where the predominant emphasis is on lowering infant and child mortality and less emphasis is placed on participation. The top-down approach limits responsiveness and curtails the potential for local NGOs to work within their communities to help them determine and act on their own health priorities.

Some offices within USAID have not worked directly with PVOs and NGOs, but, instead have delegated this responsibility to health program contractors. While working with PVOs and NGOs has frequently been included in contractors' scopes of work, there is little evidence that contractors have the capacity to do this in a way that maximizes the potential contribution PVOs could make to promote sustainability through participation. For example, the PRITECH contract has shown that when NGO interventions are called for, they may be neglected until the project is virtually completed because contractors have little understanding of how NGO participation may strengthen a program.

Donor funding mechanisms, or project documents, may include such a high degree of detail that there is little scope for incorporating major changes in program strategies or priorities in response to changing circumstances. Because participation by communities and local governments in project design, implementation and evaluation is time-consuming, it is easily neglected by donors who may recognize its theoretical value but not its practical implications.

The reporting, management and accounting standards that are required create an authoritarian rather than participatory relationship with NGOs. This drive for accountability may make it difficult for donors to recognize their dependence on PVOs and in-country organizations to actually accomplish the program.

In those circumstances where there may not be a predominant focus on 'product.' unrealistically short funding cycles may make it difficult for NGOs to plan and implement programs which are responsive to community priorities. They also make it impossible for NGOs to develop any level of sustainability. Ten year time-frames are infrequent although, in retrospect, necessary to achieve sustainable levels of participation, ownership and empowerment.

And, lastly, PVOs and NGOs which focus primarily on 'product' may create service delivery infrastructures which cannot be sustained without their presence. This response to donors who demand high levels of quantifiable results, may createdependency instead of empowerment.

Tensions Between PVOs and NGOs: Clashes in the Community

Tensions may arise between PVOs and intermediary and grass roots

organizations when their forms of governance differ. As illustrated below, the more authoritarian approach of a PVO clashed with the empowering, or democratic, approach of a grass roots organization. Dr. Vicky Guzman, Director General of ASAPROSAR, a community health organization in El Salvador, described a situation familiar to most PVOs and NGOs which are attempting to work together in community based projects (RESULTS, 1992).

> *Now since the war is over, we're seeing there is lots of money coming into the country. People from the outside now want to give us money, but they want to tell us how we should do our work. For instance, right now there is a group coming to San Salvador who doesn't want the people to build their own latrines, they want them to contract it out and let someone else build their latrines. This is against our philosophy because we really want the people to participate. The people need to change because they want to change, not because its imposed on them. The people can come in and bring the latrines for them and they might see changes in their homes and in their schools, but the 'campesinos' won't have changed within, and most likely won't be using the latrines because they will not be useful to them. There's much technology coming into the country that's really not appropriate to the culture.*

Tensions may also arise between PVOs and NGOs competing with each other for donor support. In their search for funds, PVOs and NGOs may find they are losing their identity, becoming instead simply contractors to government programs, divorced from their original mission. And when partnerships have been established between PVOs and NGOs at the community level, they may reflect an unequal balance of power instead of a partnership.

Tensions Between Governments and NGOs: Barbarians at the Gate

The voices of the people, especially when organized into NGOs, may threaten the status quo and the power structure. Active participation may be considered inherently 'subversive' because it encourages people to confront the causes of poverty and ill-health and encourages them to organize to promote change. True community participation is often opposed by those who benefit from the existing power relationships.

As NGOs increase their capacity to deliver services and gain more recognition as significant contributors to development by both donor governments and PVOs, national and local governments may monitor or control them more closely, occasionally impeding their progress in community development work. Government officials recognize that donor assistance is flowing directly to NGOs, in order to avoid excessive government control, efforts to increase government oversight may increase even more.

Reward structures for people working in NGOs are often better than they are for people in parallel positions in governments. Frequently, government employees are tempted to supplement their government salaries by working part-time for an NGO. Others leave government service altogether. Governments resent losing these motivated and skilled workers to NGOs, particularly when they earn higher salaries.

In some emerging democracies, NGOs are more accustomed to having an adversarial role in relation to their government. They have yet to learn to lead, to innovate, to develop new approaches to old problems that might then be replicated by a government on a larger scale.

NGOs find it difficult to stay informed about government priorities and actions, especially in response to new developmentnational plans. Governments find it equally difficult to know what NGOs are doing and where their priorities lie. Communications with NGOs requires a specific focus and ongoing effort by governments, PVOs and NGOs alike.

PVOs and NGOs: Into the Breach

In several countries, structural readjustment has led to a retrenchment of public sector health services. Governments have relied on NGOs to step into this breach and provide services to underserved

communities. Increased demands for services have not necessarily been matched by increased resources for services and NGOs find they are being asked to do more with less. NGOs need institutional strengthening as well as increased financial support to meet growing demands for service.

Governments may let the urgency of their mandate to work through NGOs to deliver services eclipse their consideration of the institutional capacity of a particular NGO to increase and expand its services, ignoring the fact that increased demand for services must be paralleled by an increased focus on building the institutional capacity of NGOs.

Challenges Ahead

In reviewing its many health programs and projects, USAID must first determine which of these are appropriate for PVO and NGO participation. Programs which are community based and are dependent upon communities themselves for their success lend themselves to implementation through PVOs and NGOs. Child Survival Programs which rely on community leadership and local participation provide excellent opportunities for partnerships with PVOs and NGOs if community members are well-informed and encouraged to participate in program design and implementation.

Health delivery programs can be democratized effectively through participatory processes practiced by many PVOs and NGOs. The value of democratic approaches has to recognized by donors, and included in program objectives. And as democratic goals are added, health goals may have to be broadened to provide the latitude required if programs are to respond to the values and priorities of the communities themselves. Many PVOs and NGOs want to support the health priorities of local groups, but are prevented from doing so by donor-defined goals and objectives. PVOs and NGOs have strong track records in encouraging open participation and empowering individuals and communities to identify and adopt strategies to improve their lives. They are skilled in listening to the people and supporting steps the people themselves have identified. USAID must decide how much value should be placed on community processes and how much value given to improving health indicators. Program

"success" will have to be redefined to include process indicators as well as health indicators.

Not all programs lend themselves to full partnership with PVOs and NGOs. Programs which are implemented at the regional level, such as the eradication of River Blindness, include components more effectively implemented by multilateral organizations working directly with national governments, with only a secondary emphasis on com-

munity support through PVOs and local NGOs. Once USAID has identified programs and elements of programs which are amenable to participation, the second step is to examine the roles and responsibilities of PVOs and NGOs in providing health interventions while concurrently strengthening civic participation. There are three components of this examination: the existence of PVOs and NGOs, the capacity of these organizations, and the environments in which they function.

In order to exist, organizations need resources and technical assistance to be effective. This institution building needs to be done carefully to enable PVOs and NGOs to maintain their values and sense of ownership and autonomy. Technical assistance needs to be related to existing organizational expertise and potential for growth.

The capacity of PVOs and NGOs for advocacy and participation in policy development, and for service delivery needs to be reviewed. Advocacy and service delivery are two very distinct sets of skills. Both are needed, but both may not responsibly be undertaken by every organization. Strategies for increasing advocacy skills need to be developed among NGOs in most countries which are newly merging democracies. At the same time, those organizations with a predominant capability inservice delivery should also be strengthened. Organizations which are working at the community level are most keenly aware of the needs of the people in those communities, yet they may not have the ability to interact at the policy level. In these instances, linkages between advocacy and service delivery need to be established so that policies are responsive to need.

One of the most important roles USAID can play is in promoting an enabling environment in which governments are encouraged to support a civil society in which diverse views can be expressed without fear of repercussion. Governments may need to be encouraged to bring PVOs and NGOs into their policy making processes by establishing fora with equal representation by government officials and NGOs representatives alike. USAID can model this inclusive approach to development by involving advocacy and service delivery organizations in all phases of program design, implementation and evaluation.

The challenge for USAID is to develop programs which recognize and support potential contributions of PVOs and NGOs. In order to meet these objectives, USAID will have to reconsider existing measures of success, redefining them to recognize the values of participatory decision making by fully informed communities. This process

of reexamination will need to incorporate recognition of the basic similarities in participatory health programs and promotion of democracy. It will also need to reassess the values of promoting specific health interventions in comparison to the values of empowering NGOs and communities to determine for themselves what interventions should be adopted. Fortunately, as observed in the example of Jumla, Nepal, health objectives and democracy-building objectives can converge, promoting health while practicing more open democratic approaches to development.

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